Staff Meeting Bulletin
Hospitals of the » » »
University of Minnesota

Psychogenic Torticollis

Vol. XIX Friday, November 21, 1947 No.

STAFF MEETING BULLETIN
HOSPITALS OF THE . . .
UNIVERSITY OF MINNESOTA

Volume XIX | Friday, November 21, 1947 | Number 8

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Published for the General Staff Meeting each week during the school year, October to June, inclusive.

Doctor William A. O'Brien

Rarely does one have the privilege of acquaintance with a personality so unique as that of Dr. O'Brien. His sudden death last weekend causes a sense of great personal loss not only to those of us who were his intimate friends but also thousands of people in our state and nation who know him only by name.

"Bill" O'Brien or "O B", as most of us knew him, was graduated from St. Louis University Medical School in 1914 at the age of 21. He engaged in the private practice of medicine in Detroit, Michigan, for two years before and two years after World War I. During this war he served as a medical officer in the U. S. Army.

Dr. O'Brien first came to Minnesota in 1921 for the express purpose of taking most of the medical course over again, saying that he wanted to know more before going on with practice. Last Saturday he passed away, one of the most widely known and beloved citizens of this state.

The positions which Dr. O'Brien occupied and the roles which he played have no counterpart here or elsewhere. They were developed by and for him and were identified with his personality.

His early years on the staff of our Medical School were spent as an instructor in pathology. Here it soon became obvious that he was a born teacher--that he could command and hold the interest of students and make the difficult easy.

His next position was as pathologist at the University Hospital and director of the course in medical technology. The conferences which he started while pathologist at the hospital were later expanded into the weekly general staff meetings, which bring us together here today. His broad and sincere interest in all fields of medicine and his warm and genial personality as presiding officer have been major factors in the continued success of these meetings. He was responsible, too, for the development of the weekly Staff Bulletin which today goes not only to the current members of the hospital staff but also to hundreds of former house officers and alumni of the Medical School.

Under Dr. O'Brien's leadership the course in medical technology gained a national reputation and, I am sure, that every graduate of this course felt a personal debt of gratitude and affection for Dr. O'Brien.

It was also during his period of service as hospital pathologist that Dr. O'Brien inaugurated the popular Orientation Clinics for freshman and sophomore medical students. He was a master at this type of teaching and his interest and participation in these clinics never waned.

In more recent years Dr. O'Brien's official position has been Professor of Public Health and Director of Postgraduate Medical Education. In this latter capacity he developed a unique program of continuation study courses for physicians and allied groups working in the broad fields of medicine and health. This program, which was supported first by the Commonwealth Fund of New York and more recently by the Kellogg Foundation of Michigan, has received national recognition and has made an important contribution to better medical and health services in the Upper Midwest.

Through these activities Dr. O'Brien was known and beloved by the medical and allied professions. But the general public learned to know him, to enjoy him and to believe in him through his radio health talks over a period of almost twenty years; through the classes that he taught to thousands of University students; through his many public talks and addresses and in recent years through his widely syndicated health column. As a master of ceremonies and as an after dinner speaker Dr. O'Brien was always in demand. Yet he never failed to interest his audience or to leave them with a worthwhile message.

He was a leader also and a wise counsellor to many voluntary health organizations. Of these the Minnesota Cancer Society, of which he has been president for some years, was probably his major interest. He felt that the public must be made to understand what scientists now know about cancer and to appreciate the necessity of liberal support for further research on this and other diseases.

Dr. O'Brien was a person of great human warmth, who radiated a source of

well being and good cheer. He was a genial friend who inspired confidence in all who came within his sphere, and an inspired teacher who had a profound affection for all mankind.

Dr. O'Brien loved people and was a man of vast acquaintances. Few have been privileged to know personally so many people throughout the state and few have cherished these friendships so deeply. Apart from his family they were his most prized possessions. He also knew human nature and had a singularly broad understanding of young and old alike.

Through his many activities Dr. O'Brien touched the lives and contributed to the better health of countless grateful people--people who are saddened by his passing but who will remember him with warm affection and with the feeling that their lives are better and richer for having known him. Of him the following verse might well have been written:

When a star is quenched on high,
  For ages will its light
Still travel downward from the sky,
  Shine on our mortal sight.
So, when a good man dies,
  For years beyond our ken
The light he leaves behind him lies
  Upon the path of men.*

It has been suggested that in tribute to Dr. O'Brien we might dismiss our staff meeting for today but to me it seems that the best tribute we can pay to him is to carry on with the meetings which he inaugurated and in which he was so deeply interested. So as we pick up the torch and prepare to carry on the work which he would wish to have continued without interruption, we pause today to pay tribute to his memory and to say simply as he would have it, "Well done, Dr. O'Brien".

Harold S. Diehl, Dean

November 21, 1947

*"In Memoriam", J.A.M.A. 116:2693, June 14, 1941.

I.

UNIVERSITY OF MINNESOTA MEDICAL SCHOOL
CALENDAR OF EVENTS
November 24 - November 29, 1947

No. 178

Monday, November 24

9:00 - 9:50 Roentgenology-Medicine Conference; L. G. Rigler, C. J. Watson and Staff; Todd Amphitheater, U.H.

9:00 - 10:50 Obstetrics and Gynecology Conference; J. L. McKelvey and Staff; Interns' Quarters, U.H.

9:15 - Fracture Rounds; A. A. Zierold and Staff; Ward A: Minneapolis General Hospital.

10:00 - 12:00 Neurology Ward Rounds; A. B. Baker and Staff; Station 50, U.H.

11:00 - 11:50 Physical Medicine Conference; Diagnostic Methods in Peripheral Vascular Disease; G. Keith Stillwell; E-101, U.H.

11:00 - 11:50 Roentgenology-Medicine Conference; Staff; Veterans' Hospital.

11:00 - 12:00 Cancer Clinic; K. Stenstrom and D. State; Eustis Amphitheater, U.H.

12:00 - 12:50 Physiology Seminar; Studies in Enzyme Synthesis; Saul Spiegelman, Bacteriology Dept., Washington University, St. Louis, Missouri; 214 M.H.

12:15 - 1:20 Pediatrics Seminar; The Emotional and Social Problems of the Adolescent; Hunter H. Comly; 6th Floor Seminar Room, U.H.

12:15 - 1:20 Obstetrics and Gynecology Journal Club; M-435, U.H.

12:30 - 1:20 Pathology Seminar; Experimental Nephritis in Mice Induced by Urethane; Jack Gordon; 104 I.A.

12:30 - 1:50 Surgery Grand Rounds; A. A. Zierold, Clarence Dennis and Staff; Minneapolis General Hospital.

4:00 - 5:00 School of Public Health Seminar; Familial Factors in Rheumatic Fever; S. T. Thomson; 113 MeS.

Tuesday, November 25

8:30 - 10:20 Surgery Seminar; Lyle Hay; Small Conference Room, Bldg. I, Veterans' Hospital.

9:00 - 9:50 Roentgenology-Pediatrics Conference; L. G. Rigler, I. McQuarrie and Staff; Eustis Amphitheater, U.H.

10:30 - 11:50 Surgical Pathological Conference; Lyle Hay and Nathanial Lufkin; Veterans' Hospital.

12:30 - 1:20 Pathology Conference; Autopsies; Pathology Staff; 102 I.A.

2:00 - 2:50 Dermatology and Syphilology Conference; H. E. Michelson and Staff; Bldg. III, Veterans' Hospital.

3:15 - 4:20 Gynecology Chart Conference; J. L. McKelvey and Staff; Station 54, U.H.

3:30 - 4:20 Clinical Pathological Conference; Staff; Veterans' Hospital.

4:00 - 5:30 Surgery-Physiology Conference; O. H. Wangensteen and M. L. Visscher; Eustis Amphitheater, U.H.

5:00 - 5:50 Roentgenology Diagnosis Conference; Leo G. Rigler and Staff of the University Hospital; M-515, U.H.

Wednesday, November 26

8:00 - 8:50 Surgery Journal Club; O. H. Wangensteen and Staff; M-515, U.H.

8:30 - 12:00 Neurology Rehabilitation and Case Conference; A. B. Baker and Joe R. Brown; Veterans' Hospital.

11:00 - 11:50 Pathology-Medicine-Surgery Conference; Cancer of Stomach; E. T. Bell, O. H. Wangensteen, C. J. Watson, and Staff; Todd Amphitheater, U.H.

4:00 - 5:00 Infectious Disease Routes, Todd Amphitheater, General Hospital, Veterans' Hospital.

Thursday, November 27 (Holiday)

Friday, November 28

8:30 - 10:00 Neurology Grand Rounds; A. B. Baker and Staff; Station 50, U.H.

9:00 - 10:30 Pediatric Grand Rounds; I. McQuarrie and Staff; Eustis Amphitheater, U.H.

9:00 - 9:50 Medicine Grand Rounds; C. J. Watson and Staff; Todd Amphitheater, U.H.

10:00 - 11:50 Medicine Ward Rounds; C. J. Watson and Staff; E-221, U.H.

10:30 - 11:20 Medicine Grand Rounds; Staff; Veterans' Hospital.

10:30 - 11:50 Otolaryngology Case Studies; L. R. Boies and Staff; Out-Patient Department, U.H.

11:00 - 12:00 Surgery-Pediatric Conference; C. Dennis, A. V. Stoesser and Staffs; Minneapolis General Hospital.

11:30 - 12:50 University of Minnesota Hospitals General Staff Meeting; Football Pictures; Administration; New Powell Hall Amphitheater.

1:00 - 1:50 Dermatology and Syphilology; Presentation of Selected Cases of the Week; H. E. Michelson and Staff; W-312, U.H.

1:00 - 2:50 Neurosurgery Roentgenology Conference; W. T. Peyton, Harold O. Peterson and Staff; Todd Amphitheater, U.H.

3:00 - 3:50 Surgery Literature Conference; Clarence Dennis and Staff; Minneapolis General Hospital.

4:00 - 5:00 Pediatric-Surgery Conference; I. McQuarrie, O. H. Wangensteen and Staffs; 6th Floor, Child Psychiatry Clinic.

Saturday, November 29

7:45 - 8:50 Orthopedics Conference; Wallace H. Cole and Staff; Station 21, U.H.

8:30 - 10:00 Psychiatry and Neurology Grand Rounds; Staff; University Hospital.

9:00 - 9:50 Surgery-Roentgenology Conference; O. H. Wangensteen, L. G. Rigler, and Staff; Todd Amphitheater, U.H.

9:00 - 9:50 Medicine Case Presentation; C. J. Watson and Staff; M-515, U.H.

10:00 - 11:50 Medicine Ward Rounds; C. J. Watson and Staff; M-515, U.H.

10:00 - 12:50 Obstetrics and Gynecology Grand Rounds; J. L. McKelvey and Staff; Station 44, U.H.

11:00 - 12:20 Anatomy Seminar; Effect of Urethane on Mouse Leukemia; Chen-shan Lu; Spontaneous and Induced Tumors of the Adrenal Cortex of Mice; Marthella Frantz; 226 I.A.

II. PSYCHOGENIC TORTICOLLIS

Louis L. Flynn, Jr.

During the past two years, we at the Fort Snelling Veterans Hospital have had a series of six (6) cases of psychogenic torticollis. These cases have been strikingly similar in regard to clinical picture, personalities of the patients, dynamic factors, and the symbolism of the symptomatology presented. We felt that a study of the records of this type of case would yield interesting material from an historical point of view and perhaps be of definite value in diagnosis, treatment and prognosis of other cases of this type.

We further feel that our findings will be of particular interest to neuropsychiatrists, orthopedists and physiotherapists.

By way of definition, torticollis is an involuntary twisting or turning of the neck, often accompanied by some degree of dorsal or ventral flexion. The illness may vary in severity from a barely noticeable turning, which may be alleviated by mild sedation, alcohol or reassurance, to a violent and almost totally incapacitating illness, which causes the patient great pain and may even lead to physical exhaustion.

The neck muscles appear to be in spasm and this becomes more pronounced when the patient voluntarily tries to right the head. The head can usually be righted by passive flexion. All the psychogenic cases ceased during sleep and were aggravated by stressful situations. The picture is constant throughout the patient's waking moments. The head is held in a position of maximum comfort to the patient; any deviation from this causes increased spasm.

Psychogenic torticollis must be differentiated from the torsion spasm of dystonia musculorum, myoclouus, tics and spasms of organic etiology.

History

The medical literature on torticollis is exceedingly sparse and is concerned principally with cases having organic etiology. The majority of cases are dismissed as being functional. A fair number of cases are diagnosed as hysteria with no mention of the dynamics involved. The results of treatment have apparently been poor except in the purely hysterical cases having a superficial basis and an obvious primary gain.

In studying this illness we searched the records of the Fort Snelling Veterans Hospital and have found only thirteen (13) cases of torticollis diagnosed since this hospital opened twenty years ago. We have taken all the significant data available in the clinical charts and the social service records and compiled the following short case summaries. There were two diagnosed in the period prior to 1945 which were not included in this discussion because we were unable to obtain the records.

Case #1

A middle-aged World War I veteran admitted April 12, 1930 because of numerous anxiety symptoms, torticollis and "pain, stiffness and drawing sensation" in the left side of the neck. History and records revealed that his complaints arose following an attack of meningitis while he was in the service in World War I. He had a residual cervical radiculitis (C_3) with atrophy of the left shoulder and arm. A neuropsychiatric consultation stressed the organic features and the neurasthenia but did not relate the torticollis to either.

The diagnoses on discharge were:

1. Neurasthenia
2. Cervical radiculitis with atrophy of muscles of the left arm and shoulder.
3. Torticollis - cause undetermined.

Treatment consisted of physiotherapy. The patient was discharged unimproved.

Case #2

Case #2 is a middle-aged World War I veteran who was first admitted to this hospital in February 1937. The history revealed a sudden onset a few months before admission of periodic shakiness of arms, hands, neck and head which were described as "trembling spell." The torticollis is understood to have arisen at the same time and to have persisted between and during his "spells," but this is not precisely stated in the record. The patient was kept on the medical service where a diagnosis of toxic goiter was confirmed. Neuropsychiatric consultations stated that the torticollis was an hysterical phenomenon. The patient received no neuropsychiatric treatment and was discharged with no improvement in the torticollis.

This patient was readmitted to this hospital approximately two years later for treatment of the torticollis. He was seen again in consultation by the same phychiatrist who had previously made a diagnosis of hysteria. This time no neuropsychiatric diagnosis was made. Furthermore, the consultation definitely stated that this case was "not believed to be functional."

The patient was discharged unimproved with the following diagnoses:

1. Chronic cervical arthritis
2. Torticollis (secondary to diagnosis #1)

Case #3

Case #3 is a 37 year old World War I veteran admitted August 16, 1937 whose symptoms consisted of dizziness, weak spells, intermittent numbness of hands and feet and a marked head tremor and torticollis in which the head turned to the right. The patient had influenza and encephalitis prior to 1919 while he was in the Navy. He was honorably discharged, later re-enlisting and serving until 1922 when he again received an honorable discharge. He was drawing a pension for a neuropsychiatric condition supposedly incurred in service. Since his last period of service he has been hospitalized many times for a wide variety of complaints. He had not worked for ten years prior to this admission and was a domicilliary patient in a soldier's home for one year prior to this hospitalization. The patient dated the onset of all his complaints to his first period of service. His medical record does not bear this out. He received no psychiatric treatment at this hospital and was discharged unimproved.

Psychiatric examination noted the neurasthenic features but did not relate the torticollis to the neurasthenia. The diagnosis was:

1. Neurasthenia
2. Torticollis, cause undetermined

Case #4

Case #4 is a 51 year old World War I veteran admitted October 8, 1941. He came to the hospital for a hernia repair. The history revealed that the patient had many complaints, the most outstanding of which were inability to work, weakness, rheumatism, dizzy spells and vomitting after meals in spite of having tried numerous diets and medications. No pathology was found other than a small inguinal hernia.

The diagnosis of torticollis was made twenty days after admission. This was treated by physiotherapy only. There is no description of the disease or its response to treatment other than the simple statement that the condition had improved.

The patient was discharged with the following diagnosis:

1. Hernia, inguinal
2. Torticollis, cause undetermined

No neuropsychiatric diagnosis was made.

Case #5

A 27 year old World War II veteran admitted February 13, 1946, for torticollis. He had been wounded in combat and had been a prisoner of war in Germany for 15 months. He had been receiving a pension for malaria and residual of a gun shot wound of right deltoid muscle. His torticollis began about six weeks before admission with a spasmodic jerking of the head associated with a feeling of nervous tension. On admission the head was tilted to the right and the chin was rotated to the left.

No evidence of organic pathology was found. The patient was treated with physiotherapy, bed rest, physostigmine and sedation with some improvement.

The patient was discharged with a diagnosis of functional torticollis and the final summary of the case states, "It was the opinion of the consultant that no treatment would be of much value." No neuropsychiatric consultation was requested.

At this time I wish to pause in order to point out that up to and including case #5 there had been only seven cases of torticollis diagnosed in this hospital. Only one of these was definitely diagnosed as being of functional origin. None of these cases were treated on the neuropsychiatric service of this hospital. The torticollis was evidently considered to be an incidental finding, not of sufficient importance to merit a thorough work-up. About December 1946 a marked change in attitude occurred. After that date, all cases of torticollis recorded were treated as psychiatric problems. In addition, detailed social histories were taken and intensive psychotherapy was attempted.

I shall now review the case histories of all patients seen in this hospital after October 1946. All conclusions regarding personality traits and dynamic factors were reached only after a thorough knowledge of the patient was obtained through history, personal interview and prolonged observation.

Case #6

The patient is a veteran who first noticed a tenseness or weakness of his neck while serving in the armed forces. He had constructed a special head rest so he could read, enjoy movies, etc., without tiring his neck too greatly. His symptoms began to interfere with his work about October 1946.

The history revealed no nervous or mental illness in the family and family relationships were normal. The patient was the tenth of eleven children and was somewhat retarded in school. He worked as a barber from the age of fourteen and all his life he was a steady worker and contributed to the family. Sexual history revealed mutual masturbation at the age of thirteen. He had his first heterosexual experience at the age of 16 and contacted severe gonorrhea at 18. He resumed homosexual acts at 19 and continued for four or five years. At 27 he again practiced homosexual relations for some time. He married at 30 and apparently adjusted well to heterosexual relationship. He admits, however, that he consciously desired relationships with men and resisted these desires. He first developed his symptoms in the strongly homosexual atmosphere of the Marine Corps overseas. After therapy, he left the hospital in complete remission.

Case #7

Case #7 is a veteran who first developed a spasmodic jerking of his neck in May 1945. This gradually became a fixed torticollis. He became seclusive and finally refused to eat in the mess hall or stand in the pay line because his torticollis drew attention. He was eventually hospitalized and discharged from the Navy with a diagnosis of Dementia Praecox, Paranoid type. His torticollis became more severe following discharge. He believes his neck difficulties were precipitated by a fight with his buddy. Further history revealed that the patient's father died

when the patient was five years old. The patient was an only son with five older sisters. The mother worked to support the family but suffered from two "nervous breakdowns" several years apart. The patient has a history of somnambulism, nightmares and temper tantrums in childhood. Heterosexual relations had not been attempted prior to the patient's Navy service. While in the Navy the patient consciously indulged in homosexual phantasies. He also consciously worried that he might be a homosexual. He realized that his attachment to his buddy was sexual but he resisted attempting homosexual practices. During treatment the patient came to realize that his difficulty was sexual. His torticollis improved after he was able to accept the fact that he had harbored homosexual desires. He adopted a more mature attitude toward sex and was engaged to be married before he was discharged from the hospital.

Case #8

The patient is a veteran who served with the aviation forces whose torticollis began while in combat. Flares came exceedingly close to the wing of the plane and he looked away and found he could not look back. He was treated with physiotherapy with some improvement, but the condition became much more severe after his return to civilian life.

The history revealed that the patient had never known his father. His mother had always refused to discuss his father with him and had actually attempted to give the patient the impression that he had no father. His stepfather was a quiet man with whom the patient had no emotional ties. The mother was a suspicious and domineering individual who was hospitalized in St. Peter state hospital for several months in 1938.

The patient was a religious man with a strong sense of duty. He was a good student and particular about his appearanance and his work.

As treatment progressed, it was learned that the patient had taken part in unusual sexual relationships while overseas. The patient blocked any attempt to relate this to his illness and resisted any attempt to probe into his sexual history and attitudes. As he was pushed in therapy he went AWOL, then returned, but left at his own request a short time later.

No true insight was developed and very slight improvement was noted.

Case #9

Case #9 is a veteran who received a disability discharge from the service on the basis of a diagnosis of post traumatic syndrome which was believed to have existed prior to entry into the service. He had been a chronic alcoholic while in the service and since discharge. He was a neurotic and suffered from fainting spells, nervousness, inability to work at any job or to long adjust to any situation. He also had a progressively severe torticollis of over two years duration which he believed was caused by an injury to a gland in his neck. His head was turned to the left and the chin was held against the left shoulder. The patient was of borderline intelligence.

Further history revealed that the father was an alcoholic who was unable to support his family without the help of public or private charity. The mother was nervous, high strung, ambitious and hard working. She divorced the father when the patient was very young and then supported the family herself. The patient made extremely poor heterosexual adjustments. He married a woman who is said to be a ward of the state and who has been arrested for prostitution and larceny. He never lived with her and was divorced within a short time. He has never been in trouble with the law and was never considered to be a problem or delinquent in spite of his low intelligence, his alcoholism and general inadequacy.

Case #10

Case #10 is a 24 year old white individual who first noticed that his neck

seemed to turn to the left while convalescing from malaria after the close of the war. The condition was noticeable only to the patient; the patient's physician merely reassured him. The torticollis became more severe until he was unable to turn his head to the right. The patient subsequently returned to the Veterans Hospital with a recurrence of his malaria. Neuropsychiatric and orthopedic consultations were ordered and the patient was soon transferred to the neuropsychiatric service.

The complete work-up revealed that the patient's parents had quarrelled a great deal for years and finally were divorced when the patient was in early adolescence. The patient was religious, conscientious, honest, and a good student. It was learned that the patient harbored an extreme ambivalence to his father. He later came to realize that he was dependent on his father and desirous of his affection. It was also discovered that there had been conscious homosexual phantasies and one homosexual experience while he was overseas. The patient felt great disgust and guilt at this experience but he eventually related his illness to this experience and only then began to improve.

Case #11

Case #11 is a veteran who had become conscious of swelling and pain in his neck. This progressed until three months later when he was unable to continue work because his head was drawn back and to the right. History revealed that the patient's mother was a nervous, rigid, religious, compulsive woman. The father was considered to be rather passive but very religious. It was strongly emphasized that the parents never quarrelled. The family seemed to have been managed by the mother. No sex instruction was ever given to the children. The patient was a good student, was religious, and had a strong sense of duty. He had an excellent military and work record. His illness began not long after his marriage. During therapy the patient finally came to realize that his wife was an overt homosexual who had never loved him and had tried to tell him in various subtle ways of her maladjustment. The patient had never consciously realized this before. He also came to realize that he was extremely ambivalent toward her and that his love was in reality a morbid dependency. He was discharged from the hospital as cured after he had come to realize these facts.

Summary and Comments

In summary, then, I wish to point out the remarkable similarity between these last six patients. All of these patients were dependent, inadequate and emotionally immature persons. In spite of this general immaturity they all tended to be compulsive and had a well developed sense of duty. They all felt their inadequacy keenly and tried to conform to accepted social standards. This is in marked contrast to the usual psychopathic or grossly hysterical personality.

All of these patients had conflicts relating to their sexual lives. In five of these cases there was an abnormal aspect to their sexuality and in the sixth case this was strongly suspected but never worked out with the patient. It is particularly significant that the two patients who did not improve with therapy could not work through their obvious sexual maladjustment.

Five of these patients were proven to have had great difficulty relating themselves to their mothers. Two of these mothers had "nervous breakdowns." All five of the mothers could collectively be described as being nervous, ambitious, aggressive and domineering.

Three of the six patients had inadequate and immature fathers while two other patients had no fathers. The general immaturity, both sexual and emotional, of these patients can fairly definitely be related to their relationships to their fathers.

All of these cases were diagnosed Conversion Reaction. This diagnosis implies hysteria. However, we believe that in all of these cases we have a compulsion rather than a conversion. It is a compulsive mechanism in that by the ritualistic performance of some seemingly meaningless activity a threatening situation is avoided.

In other words, these torticollis patients are faced with the threat of abnormal sexuality. This threat is avoided by turning away from the problem. Since most of these cases appear to be sexual problems, it is not surprising that the patients looked upwards and away from the genital region.

The mental mechanism of torticollis is in marked contrast to the mechanisms producing hysterical reactions and tic-like movements.

In my experience it has been a consistent finding that those tics which have been explained and treated successfully have proven to be an attempt of the patient to (1) face a threatening situation and re-enact it subconsciously in an attempt to learn to control the situation, or (2) act out a subconscious wish, the tic symbolizing the fulfillment of that wish. The usual torticollis patient has a more rigid superego than the hysteric and will not allow his body to take part in his subconscious wishes. The torticollis appears to act as a device by which all expression of the subconscious wish is denied to the body.

Treatment

In regard to treatment, we have found physiotherapy to be a helpful adjunct in those cases suffering from pain caused by tension, but it is of little value otherwise. Hypnotism was attempted on four of these patients and no patient was successfully hypnotized. All other forms of suggestive therapy were of little value.

We have found narcoanalysis to be of some help in uncovering significant data, but the simple presentation of this data to the patient did not effect a cure. It was necessary for the patient to reconstruct his problem from the material uncovered so that he could eventually understand his problem and his illness. We have found that strong motivation to get well is essential and, strangely enough, is often lacking. The patients in most cases had to be driven to work at the difficult task of understanding his problem.

We are not yet prepared to evaluate our results in terms of long term prognosis. Other observers have said that the prognosis is good for each single attack of the illness but the percentage of recurrences is high. As yet we have had no acute recurrences.